Adult Day Health Care Nursing

Definition: Adult Day Health Care (ADHC) Nursing Services are provided in and by the adult day health care center and are limited to the skilled procedures listed below and as ordered by a physician:

- Ostomy care
- Urinary catheter care
- Decubitus/wound care
- Tracheostomy care
- Tube feedings
- Nebulizer Treatment

Adult Day Health Care Nursing and Nursing Services, as defined in the MR/RD Waiver, cannot be received during the same day. This service is provided to recipients who are eighteen (18) or older. One unit of Adult Day Health Care Nursing includes any one or combination of the listed skilled procedures provided to a MR/RD Waiver Adult Day Health Care service recipient during one day's attendance at an Adult Day Health Care Center. Authorization for Adult Day Health Care Nursing will be separate from the Adult Day Health Care authorization and will not be day specific unless so ordered by a physician.

Providers: Centers/agencies enrolled with SCDHHS to provide Adult Day Health Care Services under the MR/RD Waiver. All Adult Day Health Care Nursing services must be provided in the Adult Day Health Care center by a licensed nurse, as ordered by a physician and within the scope of the South Carolina Nurse Practice Act or as otherwise provided within State Law.

Arranging for the Service: Adult Day Health Care Nursing services are only appropriate for those MR/RD Waiver recipients who require more nursing care than the Adult Day Health Care Center is mandated to provide under the service provision of Adult Day Health Care services. In order for Adult Day Health Care Nursing services to be authorized, the Service Coordinator must obtain a Physicians Order for the service by having the physician complete the **Community Long Term Care Adult Day Health Care Nursing/Respite Form (DHHS Form 122)**. The Service Coordinator signs the form in the case manager position. Once the **Community Long Term Care Adult Day Health Care Nursing/Respite Form (DHHS Form 122)** is obtained, you must update the consumers MR/RD Waiver budget requesting Adult Day Health Care Nursing (S88) and receive approval. Once approved, you may authorize the service. The Adult Day Health Care Nursing provider is responsible for obtaining the direct care physician's orders (**DHHS Form 122A**).

For recipients receiving MR/RD Waiver funded Residential Habilitation, Adult Day Health Care Nursing services are authorized using the **MR/RD Form A-34** which instructs the provider to bill the DSN Board for services rendered. The **MR/RD Form A-35** must be used **for all other recipients**. The **MR/RD Form A-35** instructs the provider to bill the South Carolina Department of Health and Human Services for services rendered.

The **MR/RD Form A-34 or A-35** will remain in effect until a new form changing the authorization is provided to the Adult Day Health Care Center or until services are terminated.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. The following criteria should be followed when monitoring Adult Day Health Care Services:

- Must complete on-site Monitorship during the first month while the service is being provided

- At least once during the second month of service
- At least quarterly thereafter

This service may be monitored during a contact with the individual/family or service provider. It may also occur during review of written documentation at the Adult Day Care Center or during an on-sight visit. Some items to consider during monitorship include:

- → Is the individual satisfied with the Adult Day Health Care Nursing?
- → Is the Adult day Health Care Nursing meeting the consumer needs?
- → Are there any additional health/safety issues not being meet by Adult Day Health Care Nursing?
- → How often does the consumer receive Adult Day Health Care Nursing?
- → What type of care is the individual receiving?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /___/___/___/___/___/___/___/___/

_____**Adult Day Health Care Nursing Services (X2045)**

Number of units/week:_____ (one unit=one day of ADHC Nursing)

Start Date:_____

Service Coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-34 (6/06)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

_____**Adult Day Health Care Services**

Number of units/week:_____ (one unit=one day of ADHC Nursing)

Start Date:_____

REMIT BILL TO (Please print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-35 (6/06)

COMMUNITY LONG TERM CARE FROM:

ADULT DAY HEALTH CARE/RESPITE FORM

CLIENT NAME: _____

SOCIAL SECURITY NUMBER _____ MEDICAID NUMBER _____

DIAGNOSIS: PRIMARY _____

(CURRENT) SECONDARY

MEDICAL HISTORY: _____

PHYSICAL EXAMINATION: T [ ] P [ ] R [ ] BP [ ]

LABORATORY DATA:

EENT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GENITOURINARY:

MUSCULOSKELETAL:

SKIN:

ENDOCRINE:

ALLERGIES: _____

DIET:

SPECIAL CARE REQUIREMENTS: (List any daily activity limitations, special therapies or special care requirements):

Is the individual capable of self-administering their own medication(s)? [ ] Yes [ ] No

MEDICATIONS	DOSE/FREQ/ROUTE	MEDICATIONS	DOSE/FREQ/ROUTE

The following procedures may be performed at an Adult Day Health Care by a nurse who will call for direct care orders.

Please indicate frequency per week or month. _____ Ostomy Care _____ Catheter Care

_____ Tube Feeding _____ Decubitus/Wound Care _____ Tracheostomy Care

I ATTEST TO THE MEDICAL NECESSITY OF THE FOLLOWING SERVICES FOR THIS CLTC PROGRAM PARTICIPANT:

ADULT DAY HEALTH CARE _____ ADULT DAY HEALTH CARE NURSING _____

RESPITE CARE NURSING HOME/HOSPITAL _____ RESPITE CARE COMMUNITY RESIDENTIAL CARE FACILITY _____

SIGNATURE OF PHYSICIAN _____ DATE: _____

SIGNATURE OF CASE MANAGER

DATE:

DATE SENT: INITIALS: